

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

08G224

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

R-C

12/16/2010

NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE

886 1/2 8TH STREET NE

WASHINGTON, DC 20019

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)

(X5)
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DATE

(W 000)

INITIAL COMMENTS

(W 000)

A follow-up survey was conducted on December 15, 2010 to verify that the facility had implemented their plan (submitted December 14, 2010) to resolve an Immediate Jeopardy (IJ) that was found to exist on November 29, 2010. Through observations of the clients and their adaptive equipment, interviews with direct support, nursing and administrative staff as well as a review of the clients' records, the determination was made that the facility had not taken sufficient corrective action to remove the IJ. Specifically, the facility failed to provide transportation services and/or necessary adaptive mobility equipment to ensure that two (out of six) clients received outside medical services. [See W127]

Previously, on November 24, 2010, at approximately 6:24 p.m., the Health Regulation and Licensing Administration's (HRLA), Compliance and Quality Assurance Investigation Division (CQAID) was notified by voicemail of the death of Client #1. According to the message, the client fell from his wheelchair, sustained a head injury and subsequently died while at the hospital. On November 26, 2010, the CQAID initiated an investigation to determine the facility's compliance with both Federal participation and local licensure requirements for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFID) participating in the Medicaid program.

On November 29, 2010, the Intermediate Care Facilities Division (ICFD) received a complaint from the Department on Disability Services that

RECEIVED
12-17-10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date the documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CARECO

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886 1/2 67TH STREET NE
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(W 000)	<p>Continued From page 1</p> <p>alleged clients in the facility did not have necessary adaptive equipment. The complaint further alleged that needed medical services were not being provided and the facility failed to implement dietary orders and mealtime protocols as required. A monitoring visit/investigation was initiated by the ICFD into the following allegations on November 29, 2010:</p> <ol style="list-style-type: none"> 1. Client #2's "wheelchair gurney" was reported by his occupational therapist (OT) as broken beyond repair. Allegation was substantiated. 2. Client #2's scheduled medical follow up appointments, i.e., his annual ophthalmology follow up for glaucoma and annual urology, have been cancelled due to "transportation" issues related to his wheelchair gurney. Allegation was substantiated 3. Client #2's labs ordered by his primary physician on September 1, 2010, have not been completed. The nurse stated that the labs have not been completed due to the "transportation" issues. Allegation was substantiated 4. Client #2 is prescribed a low fat, low cholesterol pureed diet with nectar thickened liquids. On the date of the review, November 23, 2010, Client #2's liquids were not presented in accordance to his prescribed diet and texture. He was provided "boost" liquid which was not thickened. Allegation was not substantiated 5. Client #2 has a mealtime positioning plan to address his risk of aspiration and choking. His 	(W 000)		

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{W 000}	<p>Continued From page 2</p> <p>plan includes elevating the head of his bed to a 20 degree angle and the using a positioning wedge to elevate the client an additional 50 degrees during and following his mealtime. On the date of the review, he was not properly positioned during his mealtime as recommended. Allegation was not substantiated</p> <p>6. The home has no system in place by which to monitor Client #2's weight. A wheelchair scale is in the home but is not currently operational. Allegation was substantiated</p> <p>7. Although the nurse and Qualified Mental Retardation Professional (QMRP) are aware that Client #2's weight is not being obtained or monitored, there is lack of monitoring of Client #2's food intake. Allegation was partially substantiated</p> <p>8. The facility does not have a positioning plan in place to address Client #2's skin integrity. Allegation was substantiated</p> <p>9. The facility was not monitoring/documenting Client #2's bowel movements. Allegation was not substantiated</p> <p>The findings of the monitoring visit/investigation were based on observations at the group home, interviews, and the review of clinical and administrative records, including incident reports. Six of the seven clients currently residing in the facility were reviewed. One additional client's record was reviewed for the death investigation. The results of the monitoring visit/investigation revealed that conditions found, posed an immediate and serious threat to the health and safety of clients residing at the facility.</p>	{W 000}		

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	<p>On November 29, 2010, at approximately 6:25 p.m. the Director of Developmental Disabilities Services (DDDS) was notified that an Immediate Jeopardy (IJ) existed at the facility. At that time, the DDDS submitted a plan to resolve the IJ, however the plan was not accepted by the State Agency.</p> <p>Note: On November 23, 2010, an investigation was initiated on Client #1. An incident report dated November 17, 2010, reflected that Client 1's right index finger was fractured. The cause of the injury was unknown. It should further be noted that the investigation was not completed due to the death of Client #1. This report includes deficiencies from the preliminary investigation into this incident.</p>			
{W 102}	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on interview, and record review, the facility's Governing Body failed to develop and implement policies and procedures to ensure each client had a safe and operable wheelchair [See W149] and failed to ensure effective staff training programs were developed and implemented to ensure client safety. [See W189 and W192].</p> <p>The effects of these systematic practices resulted in the Governing Body's failure to</p>	{W 102}	<p>W102</p> <p>This CONDITION will be met as follows:</p> <p>Careco has implemented a new Adaptive Equipment Protocol to ensure each client has safe and operable adaptive equipment which includes quarterly preventative reviews from PT & OT. Recommendations pertaining to this equipment will be reviewed by the QMRPs and the Deputy Director. This information will be forwarded to an interdisciplinary team and included in the Quality Improvement reports which shall be reported out to senior leadership on a routine basis. All QMRPs, Residence Directors, RNs and LPN Coordinators have been trained on the implementation of the Adaptive Equipment Policy and Protocol implementation. All Direct Support Staff who work with Client #2, #3, #4, #5 and #6 have been trained on it.</p> <p>3/7/11</p>	

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{W 102}	Continued From page 4 manage the facility in a manner that would ensure clients' health and safety. [See W122]	{W 102}	W104 This CONDITION will be met as evidenced by:	
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's Governing Body failed to provide general operating direction, for six of the seven clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. [Cross-refer to W127 and W136] The Governing Body failed to protect and ensure the health, safety and community integration of each client by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, air mattresses, shower chairs and or gurneys). 2. [Cross-refer to W149] The Governing Body failed to develop policies and procedures on wheelchair monitoring to ensure client safety.	{W 104}	1. Careco has implemented a protocol for tracking the status of adaptive equipment and has trained staff on its implementation. Careco has made alternative arrangements for clients to receive in-home medical care when the status of their adaptive equipment prevents them from leaving the home. Alternate arrangements include PCP providing services in the home, in-home labs, hiring a recreational therapist, using loaner wheelchairs/adaptive equipment, using transportation vendors and receiving in-home community integration. This information will be forwarded to an interdisciplinary team and included in the Quality Improvement reports which shall be reported out to senior leadership on a routine basis. 1/19/11	1.19.11
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility	{W 122}	2. Careco Inc has implemented an adaptive equipment protocol that outlines the procedure for tracking adaptive equipment including wheelchair monitoring in the homes. On a quarterly basis, OT/PT will review adaptive equipment as part of a preventative maintenance measure. Concerns pertaining to adaptive equipment will be reviewed by the Quality Improvement Committee where an interdisciplinary team will provide appropriate care solutions. 1/30/11	1.30.11

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{W 122}	Continued From page 5 failed to ensure systems were designed and/or implemented to make certain clients were not subjected to physical injuries [See W127]; failed to ensure that clients participated in community outings in accordance with their annual plans [See W136]; failed to implement policies and procedures that ensured clients' health and safety [See W149]; and failed to ensure that all injuries of unknown origin were reported [See W153]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety. [Also see W158]	{W 122}	W122 This CONDITION will be met as follows: Protocols have been put in place to ensure that physical injuries to clients are minimized. The adaptive equipment protocol includes client safety measures such as: - Alternate arrangements for clients to receive community outings accordance to their annual plans [See response to W136]. - Current policies and protocols have been created and implemented to ensure the health and safety of the clients in our care. -[See response to W149] and staff have been retrained to ensure that all incidents of unknown origin are reported. [See response to W153] 12/31/10	12-31-10
{W 127}	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the health and safety of each client by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, shower chairs and/or gurneys) as prescribed and/or provided transportation services, for four of the six clients currently residing in the facility. (Clients #2, #3, #4 and #5) The findings include: 1. On December 15, 2010, at 8:00 a.m., Client #2 remained without transportation to facilitate	{W 127}		

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Continued From page 6
outside medical services, as evidenced below:

a. Client #2 was observed in his hospital bed when the revisit began, at 7:48 a.m. At 12:30 p.m., a new custom molded gurney wheelchair was delivered to the facility by the wheelchair vendor. However, interview with the Interim Director of Developmental Services (IDDS) revealed that the physical therapist (PT) would first need to assess the new gurney wheelchair to verify that it meets Client #2's specific needs. As of 5:33 p.m., the facility had not secured an appointment with the PT.

At 5:25 p.m., interview with the facility's quality assurance (QA) specialist revealed that he had just taken measurements of Client #2's new gurney wheelchair. He questioned whether the vehicle previously-identified for transporting the client would be able to accommodate the wheelchair. He further indicated that he would have his "specialist" examine the vehicle and determine whether the facility would need to order additional tie down straps.

In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated, "arrangements have been made with <transportation vendor> to transport Client #2 to medical appointments in the absence of his wheelchair." At 1:40 p.m., interview with registered nurse (RN) revealed that an application form for such services had been transmitted via facsimile to the transportation vendor on the day before (December 14, 2010). According to the IDDS, at 3:25 p.m., the application process required 24-48 hours to determine his eligibility for services. Moments later, review of the application form

(W 127)

W127

This STANDARD will be met as follows:

1. a-c Client #2 Wheelchair was delivered on 12/15/10. The PT came to assess the Client #2 wheelchair on 12/17/10. Careco Inc has a wheelchair van that will be fitted to accommodate Client #2 wheelchair. In the event that this vehicle is not functioning or Client #2 wheelchair is broken, he will be transported by a transportation company to his medical appointments. Client #2 blood and urine levels were obtained by Genesis 1 Phlebotomy Service Inc on December 15, 2010 according to the RN the levels were within normal limits. The new QMRP for the home was trained on the adaptive equipment protocol that includes documenting the status on progress notes of all adaptive equipment. 2/30/11
2. a-b Client #2 Wheelchair had been maintained according to Careco Inc.

2-30-11

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{W 127}	<p>Continued From page 7</p> <p>verified that it had indeed been dated December 14, 2010. At approximately 4:30 p.m., Client #2's Service Coordinator with the Department of Disability Services (DDS) introduced herself to the survey team. She stated that the transportation vendor previously identified by the facility had informed her approximately one week earlier that they did not transport clients who reside in intermediate care facilities (ICFs). At 4:50 p.m., during a teleconference with the facility's administrator and the state agency, the DDS acknowledged that to date, no alternative transportation services had been sought.</p> <p>b. On December 15, 2010, at 10:15 a.m., review of Client #2's medical record revealed a lab report indicating that serum and urine samples had been obtained on December 9, 2010. The lab report showed several abnormal readings including a high serum level for dilantin. Moments later, review of a nurse progress note dated December 13, 2010 revealed that a licensed practical nurse (LPN) had reviewed the lab results and had left a message on the primary care physician's (PCP) telephone service that day. On December 14, 2010, the same LPN documented the PCP's telephone order to decrease Client #2's dilantin and to retest his dilantin levels on December 16, 2010. At 11:46 a.m., the LPN stated that a nurse would come to the facility the next day (December 16, 2010) to obtain new serum and urine samples.</p> <p>At approximately 4:45 p.m., interview with the DDS and the DDS Service Coordinator revealed that Client #2 had continued missing medical appointments due to the lack of transportation. Previously, the client had an ophthalmology appointment rescheduled from November 5,</p>	{W 127}	<p>policies and procedures. Client #2's loaner chair was repaired on 12/8/10; on 12/14/10 the seatbelt was "loose" so DSP staff followed the established protocols and did not transport Client #2. Within 24 hours Client #2 wheelchair was repaired. Subsequently, Client #2's medical appointments were rescheduled and completed. Careco will have access to loaner chairs provided by Kaycee Drugs.</p> <p>12/31/10</p> <p>3. The RD and the staff person involved (SS) were retrained by the PT on 12/17/10 on the correct position of the anti-tippers.</p> <p>12/17/10</p> <p>4. Client #5 shower gurney has been discontinued by the Occupational Therapist. This was included as an addendum to the note written on 11/1/10</p> <p>11/1/10</p>	<p>12-31-10</p> <p>12-17-10</p> <p>11-1-10</p>

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(W 127)	<p>Continued From page 8</p> <p>2010 to December 2, 2010. He did not, however, make it to the December 2, 2010 appointment. Similarly, he missed a December 10, 2010 urology appointment which had originally been scheduled for November 9, 2010. As of December 15, 2010, Client #2 remained without transportation services and was, therefore, not receiving medical services outside of the facility.</p> <p>c. It should be noted that on December 15, 2010, Client #2 remained without a shower gurney, two months after it was ordered by the PCP. At 9:45 a.m., interview with the IDDS revealed that a second 719A form had been submitted for the shower gurney. She presented a 719A form that was signed by the PCP on November 30, 2010. Moments later, review of the client's qualified mental retardation professional (QMRP) progress note on adaptive equipment, dated December 13, 2010, failed to reflect the status of the shower gurney. In the meantime, the PCP wrote an order on December 8, 2010, for Client #2 to continue receiving bed baths while awaiting the shower gurney.</p> <p>2. The facility failed to maintain Client #3's wheelchair to ensure that he received outside medical services, as evidenced below:</p> <p>a. On December 15, 2010, from 7:48 a.m. until 12:45 p.m., Client #3 was observed in his hospital bed. At 12:30 p.m., the wheelchair vendor arrived in the facility and repaired the safety belt on the client's wheelchair. At 12:43 p.m., interview with the LPN revealed that on the day before (December 14, 2010), Client #3's wheelchair seatbelt had been loose on the right side; the wheelchair was deemed unsafe. The nurse further indicated that because the seatbelt</p>	(W 127)		12-31-10

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(W 127)	<p>Continued From page 9</p> <p>could not be secured properly, the client had missed two medical appointments (wound care clinic and PCP) that were scheduled for December 14, 2010.</p> <p>At approximately 1:45 p.m., interview with the RD and IDDS revealed that the same seatbelt on the loaner wheelchair had been repaired previously, on December 8, 2010. Then on morning of December 14, 2010, "the other side" of the seatbelt had "come loose." During the exit conference, at 5:00 p.m., the IDDS acknowledged that the facility had not made another wheelchair available for Client #3 on the previous day, to ensure that he kept his appointments.</p> <p>b. In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated the QMRP was "following the Medicare process for obtaining a custom molded wheelchair for Client #3. <Wheelchair vendor> had indicated that Medicare is requesting face-to-face visit with his <PCP> before they will authorized payment for ... new wheelchair." At approximately 4:00 p.m., interview with the LPN revealed that Client #3 had not had a "face-to-face" visit with the PCP. The PCP, however, wrote a prescription for Client #3 to receive a custom made wheelchair and a rolling shower chair/commode with waist belt. She presented the prescription and corresponding consultation form, which had both been signed and dated December 14, 2010 by the PCP. At approximately 4:10 p.m., follow-up interview with the RN and the same LPN again revealed that the client was not seen by the PCP on December 14, 2010. They further explained that the PCP "sees him frequently."</p>	(W 127)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 127)	<p>Continued From page 10</p> <p>3. On December 15, 2010, at 8:37 a.m., Client #4 was observed seated in his wheelchair. The wheelchair's anti-tippers were in the up position. Interview with a direct support staff who was working with the client indicated that the anti-tippers were used to help support the wheelchair from tipping backwards, when going up a hill. The staff did not, however, state how the anti-tippers should be positioned. At 9:07 a.m., the staff was observed propelling the client toward the door. The anti-tippers were still in the up position. At 9:15 a.m., the RD was observed pushing Client #4 outside towards the van. Again, the anti-tippers remained in the up position. When brought to her attention a few moments later, the IDDS acknowledged that the anti-tippers were in the up position. She (IDDS) then intervened and instructed the staff to reposition the anti-tippers in order for them to be effective. The RD and direct support staff subsequently adjusted the anti-tippers to the down position to ensure the client's safety. When interviewed by telephone at 8:50 a.m., the wheelchair vendor stated "the anti-tippers should be in the down position whenever the wheelchair is moving." It should be noted that review of the staff in-service records, at approximately 2:30 p.m., revealed that on December 8, 2010, facility staff had received training on safety and positioning in wheelchairs. Observations on the morning of December 15, 2010, however, indicated that the training had not been effective.</p> <p>4. In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated that Client #5's wheelchair had been repaired and was in safe working condition. The response letter did not</p>	(W 127)		<p>12-17-10</p> <p>11-1-10</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER

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806 1/2 57TH STREET NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 127)	<p>Continued From page 11</p> <p>reflect the recommended shower gurney stretcher for bathing. On December 15, 2010, at 8:20 a.m., inspection of the client's wheelchair confirmed that the safety strap on the left footrest had indeed been repaired. The client, however, remained without a shower gurney stretcher, and there was no evidence presented that the QMRP had brought the occupational therapist's November 1, 2010 recommendation for a shower gurney stretcher to the PCP's attention.</p> <p>Previously, the Federal Deficiency Report dated December 3, 2010, included the following:</p> <p>1. Client #1, who died from head injuries sustained in a fall from his wheelchair on November 24, 2010, was admitted to the facility in July 2008.</p> <p>a. On November 29, 2010, at approximately 6:10 p.m., interview with the qualified mental retardation professional (QMRP) revealed that Client #1 had initially been admitted with a custom molded wheelchair. The wheelchair, however, allegedly was repossessed by the wheelchair vendor shortly thereafter, due to problems with the payment. [Note: The QMRP was unsure of the actual date and review of the client's record later that evening failed to identify the exact date on which his custom molded wheelchair was removed from the facility.] Further interview with the QMRP revealed that in December 2009, the facility enlisted the support of the client's attorney in an effort to secure a custom molded wheelchair that Client #1 allegedly had been using while residing with a former provider. Those efforts, however, failed</p>	(W 127)	<p>Federal Deficiency Report 12/3/10 W127</p> <p>This STANDARD will be met as follows:</p> <ol style="list-style-type: none"> 1. a-e The new QMRP has been trained on the Adaptive Equipment Protocol and Careco Inc Adaptive Equipment Policy and Procedure. The QMRP will be expected to track and report the status of adaptive equipment in a timely fashion according to the Adaptive Equipment Protocol. DSP staff in the home have been trained on documentation and verbally reporting the status of adaptive equipment. The QMRP has been trained on the expectations around documenting adaptive equipment. QA monitored the home with the report completed and findings shared with the QMRP on 10/20/10. This was available for at the time of the survey. In the future, no individual will be transported without adaptive 	2.30.11

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AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

08G224

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

R-C

12/16/2010

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(W 127)	<p>Continued From page 12</p> <p>and the QMRP acknowledged that the facility had not initiated the formal process towards obtaining a new custom molded wheelchair.</p> <p>b. On November 30, 2010, beginning at 10:00 a.m., review of Client #1's physical therapy (PT) records revealed ongoing recommendations to obtain a custom molded wheelchair. His annual PT evaluation, dated September 22, 2008, included "consider a custom molded seating system." Then on October 13, 2008, the PT documented that the standard wheelchair, with sling type seating (the one the client was using at that time of his death) was inappropriate. He wrote "He sits on his right ilium. His trunk is shifted right. There is increased pressure on his right axilla from the right arm rest. The seating system perpetuates his scoliosis and deformities. He is at risk of skin breakdown." The PT again recommended a custom molded wheelchair. In the next annual evaluation, dated October 15, 2009, the PT wrote the client "had not received the appropriate wheelchair" and recommended "Follow-up with new custom wheelchair." On October 4, 2010, the PT performed another annual evaluation at which time he repeated the same recommendation for a custom molded wheelchair. The governing body failed to address the recommendations for a custom molded wheelchair.</p> <p>c. Similarly, review of Client #1's occupational therapy (OT) records on November 30, 2010, beginning at 10:15 a.m. revealed that the OT had repeatedly documented that the client's wheelchair did not meet his needs. An OT evaluation dated September 14, 2009, included "the wheelchair is wide and the seat and back do not provide good support. He is at great risk for</p>	(W 127)	<p>equipment in proper working condition and the QMRP will be expected to address all adaptive equipment needs in a timely fashion.</p> <p>2/30/11</p>	

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(W 127)	<p>Continued From page 13</p> <p>falls and skin breakdown in this chair. A new wheelchair evaluation and new wheelchair are strongly recommended ..." The client's most recent OT Evaluation, dated September 11, 2010, recommended a wheelchair assessment and a new wheelchair. On November 1, 2010, the OT again noted that the standard wheelchair "does not provide optimal balance, posture, or positioning." Later that month, the client died after sustaining a head injury.</p> <p>d. On November 29, 2010, at 11:30 a.m., telephone interview with the direct support staff person who had assisted Client #1 out from the van and onto the lift on the day that he fell (November 24, 2010), revealed that the buckle on the seat belt of his wheelchair had been broken for "approximately 30 days." There was no evidence, however, that the facility attempted to have the seat belt repaired. On November 29, 2010, at 7:00 p.m., observation of the wheelchair revealed that the seat belt was indeed broken. In addition, the padding on the right arm rest was completely gone (the metal frame of the arm rest was exposed).</p> <p>e. Problems with Clients #1 wheelchair were previously cited in an HRLA recertification deficiency report dated August 20, 2010. There was no evidence, however, that the governing body implemented their Plan of Correction (PoC) since it was submitted on September 23, 2010. The QMRP had not maintained running notes in Client #1's records regarding needed repairs and there was no evidence of quality assurance (QA) monitoring since the August 20, 2010 survey.</p> <p>2. Client #2 was admitted to this ICF/ID on September 7, 2010. Client #2 did not receive</p>	(W 127)		

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(W 127)	<p>Continued From page 14</p> <p>new adaptive equipment as prescribed (gurney wheelchair, shower gurney), and/or timely repairs to his existing adaptive equipment, as evidenced below:</p> <p>a. On November 29, 2010, at 3:45 p.m., a repairman was observed working on a hospital bed located in a back bedroom. The evening licensed practical nurse (LPN) indicated that the head of this hospital bed, which belonged to Client #2, could not be elevated. At 4:23 p.m., the LPN informed surveyors that the head of the hospital bed was now operating, which he then demonstrated successfully. At approximately 7:15 p.m., interview with the residence director (RD) revealed that the head of Client #2's hospital bed could not be elevated for the 83 days since he was admitted to the facility, on September 7, 2010.</p> <p>b. On November 29, 2010, at 3:50 p.m., Client #2's custom molded gurney wheelchair was observed being stored in a supply room. It was tilted to one side and the evening nurse explained that the frame was broken. Simultaneous interviews with the QMRP and RD later that evening, at 7:12 p.m., revealed that the client's gurney wheelchair had been functioning properly when he was admitted. The gurney wheelchair broke, however, on September 25, 2010. They indicated that the gurney wheelchair was assessed, and the QMRP presented her progress note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the paperwork for approval by the</p>	(W 127)	<p>2. a-d QMRP and RD have been retrained on the new Adaptive Equipment Protocol. Adaptive equipment concerns are documented. Careco Inc is using a vendor to provide in-home laboratory services when an individual is unable to leave the home. In the future, QMRP is ensuring that Client #2 ISP goals are met utilizing alternate transportation to attend his day program, medical appointments and community outings. Arrangements have been made for Client #2 friends to visit him in the home as a way to assist him in maintaining relationships. The Primary Care Physician for Client #2 has ordered the use of bed baths in the absence of a shower gurney.</p> <p>12/8/10</p>	12-8-10

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{W 127}	<p>Continued From page 15</p> <p>insurance company." As of November 30, 2010, Client #2 remained without a custom molded gurney wheelchair and was confined to the hospital bed, within the facility.</p> <p>c. On November 30, 2010, beginning at 6:00 p.m., review of Client #2's medical records revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and lipid profile." At 7:00 p.m., the QMRP confirmed that the client had missed his ophthalmology and urology appointments due to the lack of a gurney wheelchair. [Note: The appointments had been rescheduled for December 2010.] As of that evening, however, there was no finalized plan for obtaining the laboratory studies ordered on October 1, 2010. Since being confined to the hospital bed, Client #2 had not left the facility and, therefore, his community integration was restricted. It should be noted that his Individual Support Plan (ISP) dated November 9, 2009, indicated that "going to my day program and community outings" were what is most important to him. The ISP also included "It is important that I maintain optimal health, maintain a wheelchair that is in good repair and good relationships."</p> <p>d. On November 29, 2010, at 4:24 p.m., interview with the evening LPN revealed that in the 83 days since his admission, Client #2 had received bed baths only, due to the facility's failure to obtain a shower gurney. At 7:15 p.m., review of a PCP note, dated September 29, 2010, and the corresponding 719A form verified</p>	{W 127}		

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{W 127}	<p>Continued From page 16</p> <p>that Client #2 needed "a shower gurney."</p> <p>3. Client #3 was admitted from a nursing home to the facility on August 5, 2010. Client #3 did not receive new adaptive equipment as prescribed, and/or timely repairs to his existing adaptive equipment, as evidenced below:</p> <p>a. On November 29, 2010, at 3:45 p.m., Client #3 was observed sleeping in a hospital bed in his bedroom. His wheelchair was observed across the bedroom; its left armrest was detached. Interview with the evening LPN revealed that the wheelchair had "recently" broken. The detached armrest had white adhesive tape wrapped around the bottom of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. They stated that he had been admitted from a nursing home to the facility on August 5, 2010, with that wheelchair, which was in operational condition at that time.</p> <p>On November 30, 2010, beginning at 11:16 a.m., review of Client #3's ISP, dated September 7, 2010, confirmed that he utilized a wheelchair and that it was functioning at that time. Further review of the record, however, failed to show documentation of when the wheelchair had broken. At 3:00 p.m., review of Client #3's PT records revealed that he had been assessed while in the nursing home and measurements were taken for a custom molded wheelchair. On August 9, 2010, the PT again noted the need for a custom molded wheelchair. Further review revealed that a 719A form was generated on</p>	{W 127}	<p>3. a-c The QMRP and RD have been trained on the timely acquisition and repair of adaptive equipment. In the future the QMRP will follow-up in a timely fashion, document and report any concerns or barriers in obtaining adaptive equipment.</p> <p>12/8/10</p>	12-8-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/16/2010
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(W 127)	<p>Continued From page 17</p> <p>September 28, 2010, six weeks later. Another four weeks passed then on October 20, 2010, the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the wheelchair vendor indicated there were problems with the client's Medicare number. The QMRP stated that she had given the vendor the client's Medicare card later on that same day. As of November 30, 2010, the client was without a functioning wheelchair.</p> <p>b. On November 29, 2010, at 7:20 p.m., the QMRP and RD stated that Client #3 had a decubitus ulcer on his sacral area when he was admitted to the facility. On November 30, 2010, at 3:00 p.m., review of Client #3's PT records revealed that on August 17, 2010, the PT had recommended an air mattress to promote skin integrity. At 4:26 p.m., further interview with the QMRP revealed that the client received the air mattress on November 13, 2010, almost three months after it was recommended by the PT.</p> <p>c. On November 30, 2010, at 3:10 p.m., further review of Client #3's 719A form, dated September 28, 2010, revealed that the PCP also ordered a "rolling shower commode chair." A month later, on October 20, 2010, the wheelchair vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the wheelchair vendor indicated there were problems with the client's Medicare number. The QMRP stated that she had given the vendor the client's Medicare card later on that same day. As of November 30, 2010, two months later, the client was without a "rolling shower commode chair."</p>	(W 127)		

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(W 127)	Continued From page 18 4. According to a Plan of Correction (PoC) dated September 23, 2010, the QMRP indicated that repairs would be made to Client #4's wheelchair. As of November 30, 2010, the client's wheelchair still had not been repaired and the condition of his wheelchair placed him at risk, as evidenced below: a. On November 30, 2010, at 9:20 a.m., Client #4 was observed seated in his wheelchair on the lift mechanism of the facility's van. At the time, staff were loading clients to go to day program. Inspection of his wheelchair revealed that in addition to the previously identified repairs needed (mismatched wheels), the right anti-tipper was missing and the safety straps on both foot rests were unattached. After the problems with his wheelchair were brought to the staff's attention, they continued to put him on the van. At that moment, surveyors intervened and asked staff if they were aware of the administrator's directive regarding wheelchair safety and not leaving the facility. Staff then indicated that they were not aware of their administrator's directive that had been issued the previous evening. Once they were informed of the directive ("client will not be transported in... a wheelchair until it is properly repaired"), staff began wheeling Client #4 toward the facility. The client's right foot was observed dragging against the cement walkway for approximately four feet as they made their way back to the home. Record review on November 30, 2010, beginning at 9:50 a.m., revealed an OT evaluation, dated September 11, 2010, in which, the OT recommended that Client #4 receive "a wheelchair consult as current wheelchair is too	(W 127)	4. a,b Client #4 wheelchair has been repaired, he will use this wheelchair until his custom wheelchair is received. The QMRP has been retrained on new Adaptive Equipment Protocol that outlines the process for the timely acquisition and repair of adaptive equipment. 12/8/10	12-8-10

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(W 127)	<p>Continued From page 19</p> <p>small for his height." On September 28, 2010, the PT evaluated the wheelchair and concurred, writing "Chair is too small. He is at risk for lower extremity injury." On the same day (September 28, 2010), the PCP ordered a new wheelchair and signed a 718A form. A month later, on October 20, 2010, the wheelchair vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the vendor informed the facility that they had secured approval for the new wheelchair. Measurements still needed to be taken before an order could be placed and the "entire process should take about 30 days."</p> <p>b. In an HFLA recertification deficiency report dated August 20, 2010, the facility was cited for Client #4's wheelchair having "two different types of wheels ... rear left wheel was observed to have ridges in the tire while the right rear was observed to have a smooth tire." In their Plan of Correction (PoC), dated September 23, 2010, the facility stated that the "QMRP will contact the equipment vendor and have the chair repaired. The QMRP will maintain a log of contacts with the equipment vendor and follow-up to ensure that the repairs are effectuated as soon as possible," and "the QA will monitor for three months to ensure compliance." On November 30, 2010, beginning at 9:50 a.m., review of Client #4's record failed to show evidence that the QMRP had maintained a log of contacts with the equipment vendor and there was no evidence of QA (quality assurance) monitoring in accordance with the accepted PoC.</p> <p>5. The facility failed to maintain Client #5's wheelchair safety and obtain a shower gurney stretcher for bathing, as evidenced below:</p>	(W 127)		

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(W 127)	Continued From page 20 On November 30, 2010, at approximately 4:45 p.m., observation of Client #5's wheelchair revealed that the safety strap on the left footrest was broken. At approximately 5:10 p.m., review of the client's record revealed an "OT Equipment Assessment," dated November 1, 2010, in which the OT identified the broken strap on the foot rest and also recommended "a shower gurney stretcher for bathing." The QMRP was interviewed just minutes later, at which time she stated that she had not reviewed the OT's assessment prior to filing it in the client's records. She indicated that she was unaware of the damaged safety strap. She also acknowledged that she was unaware that the OT had recommended a shower gurney for Client #5, four weeks earlier. 6. The facility failed to maintain Client #5's wheelchair safety by providing the footrest on his wheelchair, as evidenced below: On November 30, 2010, at 7:35 a.m., Client #6 was observed seated in his wheelchair in the living room. The wheelchair was without a right footrest. At approximately 8:40 a.m., staff was asked about the missing footrest. The staff went to the client's bedroom and returned moments later stating that they were unable to find his footrest. At 10:15 a.m., staff indicated that Client #6 had stayed home from day program due to the condition of his wheelchair. Later that day, at 3:10 p.m., review of an OT evaluation, dated May 12, 2010, revealed that the OT had identified a broken strap and foot plate. When interviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the client had been in need of a new footrest for months.	(W 127)	5. Client #5's Wheelchair has been repaired. In an addendum to the November 30 OT note. The OT stated "...[Client #5] has bathed safely using the shower chair. Shower chair can continue to be used for bathing." In the future, the QMRP will use the established protocols and ensure repairs are obtained in a timely fashion. 11/1/10 6. Client #6's wheelchair has been repaired. In the future the QMRP will use the established protocols and ensure repairs are obtained in a timely fashion. 12/13/10	11-1-10 12-13-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE
886 1/2 67TH STREET NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 127}	Continued From page 21 They explained that his insurance company (an HMO) repeatedly had denied requests to have the wheelchair repaired. The facility failed to repair or replace the broken right footrest in the six month since the OT identified the need on May 12, 2010.	{W 127}		
{W 136}	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients participated in community outings in accordance with their annual plans, for two of the seven clients residing in the facility. (Clients #2 and #3) The findings include: 1. [Cross-refer to W127.2] Client #2 was admitted to this ICF/ID on September 7, 2010. On November 29, 2010, at 3:50 p.m., Client #2's custom molded gurney wheelchair was observed being stored in a supply room. It was tilted to one side and the evening nurse explained that the frame was broken. Simultaneous interviews with the qualified mental retardation professional (QMFP) and residence director (RD) later that evening, at 7:12 p.m., revealed that the client's gurney wheelchair had been functioning properly when he was admitted. The gurney wheelchair broke, however, on September 25, 2010. They indicated that the gurney wheelchair was assessed, and the QMFP presented her progress	{W 136}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G3224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/16/2010
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARECO

606 1/2 67TH STREET NE

WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 136)	<p>Continued From page 22</p> <p>note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." As of November 30, 2010, Client #2 remained without a custom molded gurney wheelchair and was confined to the hospital bed, within the facility.</p> <p>On November 30, 2010, beginning at 6:00 p.m., review of Client #2's medical records revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and lipid profile." At 7:00 p.m., the QMRP confirmed that the client had missed his ophthalmology and urology appointments due to the lack of a gurney wheelchair. Since being confined to the hospital bed, Client #2 had not left the facility and, therefore, his community integration was restricted. It should be noted that his Individual Support Plan (ISP) dated November 9, 2009, indicated that "going to my day program and community outings" were what is most important to him. The ISP also included "it is important that I maintain optimal health, maintain a wheelchair that is in good repair and good relationships."</p> <p>2. [Cross-refer to W127.3] On November 29, 2010, at 3:45 p.m., the left armrest on Client #3's wheelchair was observed to be detached. Interview with the evening licensed practical</p>	(W 136)	<p>W136 This STANDARD will be met as follows:</p> <ol style="list-style-type: none"> 1. Cross-reference response to W127.2 Careco is in the process of obtaining a Recreation Therapist. The Recreation Therapist will complete assessments and offer alternatives if the clients can't leave the home for community activities as scheduled. 2/30/11 2. Cross-reference response to W127.3 Client#3 is using a loaner chair. Careco is in the process of obtaining a Recreation Therapist. The Recreation Therapist will complete assessments and offer alternatives if the clients can't leave the home for community activities as scheduled. 2/30/11 	<p>2.30.11</p> <p>2.30.11</p>

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NAME OF PROVIDER OR SUPPLIER

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(W 138)	Continued From page 23 nurse (LPN) revealed that the wheelchair had "recently" broken. The detached armrest had white adhesive tape wrapped around the bottom of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. As of November 30, 2010, the client had been without a functioning wheelchair for approximately one week and, therefore, confined to the interior of the facility.	(W 138)		
(W 149)	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its policies to ensure the health and safety, for six of the seven clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. [Cross-refer to W127] The facility failed to ensure the health and safety of each client by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, air mattresses, shower chairs and/or gurneys) as prescribed, for Clients #1, #2, #3, #4, #5 and #6. 2. Staff failed to implement the facility's	(W 149)	W149 1. Cross reference response to W127 12/8/10 2. Staff will be trained on the transportation policy. In the future the RD/QMRP will follow the appropriate staffing pattern for the home. 1/6/11	12-8-10 1-6-11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 660224	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R-C 12/16/2010
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NAME OF PROVIDER OR SUPPLIER

CARECO

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686 1/2 67TH STREET NE

WASHINGTON, DC 20019

(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
{W 149}	Continued From page 24 transportation policy, as follows: On November 30, 2010, at 9:45 a.m., a driver left the facility with Client #5 to take him to day program. There was no other person observed on the van (no attendant). At 10:16 a.m., interview with the residence director (RD) revealed that the facility's policy was to have at least one other staff person on the van when they drove clients in the community. She explained, however, that they were short of staff that morning and that Client #5 usually did not exhibit significant behaviors. Later that day, at approximately 7:25 p.m., review of the facility's transportation policy, dated 2007, revealed Policy B.1.b. "When individuals are transported, an attendant (a person other than the driver) is assigned to accompany them to attend to their special needs." 3. [Cross-refer to W153] Facility staff failed to report an injury of unknown origin (Client #1's finger swollen, later determined to be broken) timely, in accordance with the facility's incident management policies. On November 23, 2010, beginning at approximately 1:00 p.m., review of the facility's incident management policy revealed that injuries of unknown origin were categorized as a serious reportable incident. The policy specifies that serious reportable incidents are to be reported to the immediate supervisor or manager and an incident report generated. There was no documented evidence that the staff (direct support and nursing) implemented the incident management policy as outlined.	{W 149}	3. Cross reference response to W157. Staff has been trained on the timely identification and reporting of incidents. When the blister was identified as an injury it was immediately reported per regulations. Direct Support and Nursing have been retrained on incident management procedures. 1/5/11	1.5.11
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS	{W 153}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G224	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R-C 12/15/2010
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STREET ADDRESS, CITY, STATE, ZIP CODE
606 1/2 67TH STREET NE
WASHINGTON, DC 20019

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(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETION DATE
{W 153}	<p>Continued From page 25</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and the Department of Health (DOH) as required, for one of the seven clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>The State Agency was notified on November 17, 2010 via facsimile of an injury of unknown origin to Client #1's finger. According to the incident report, Client #1 sustained a fracture to his right pointer (index) finger. The cause of the fracture was not noted on the incident report. An on-site investigation was initiated on November 23, 2010. Interview with the residence director (RD) on November 23, 2010, at approximately 10:30 a.m., revealed that when the incident was discovered on November 13, 2010, the client had a blister on his finger (origin was unknown). The corresponding nursing note dated November 13, 2010, acknowledged the staff's notification and noted that the pointer (index) finger of the right hand was swollen with a blister to the lower part of the finger close to the palm. The finger reportedly was not painful to touch and a cold compress was applied. The primary care physician (PCP) was notified. The PCP ordered to "continue with the cold compresses twice a</p>	{W 153}	<p>W153</p> <p>This STANDARD will be met as follows:</p> <p>The incident was initially reported on November 13, 2010 to the Administrator as a minor medical concern. It wasn't until Client #1 was taken for X-rays that it was revealed that Client #1 finger was fractured. Staff received an in-service training on the timely identification and reporting of incidents on 1/5/11. Staff will report all injuries of unknown origin as Serious Reportable Incidents according to regulatory guidelines.</p> <p>12/1/10</p>	12-1-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G224	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 885 1/2 57TH STREET NE WASHINGTON, DC 28018
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(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
{W 153}	<p>Continued From page 26</p> <p>day until resolved and to monitor for infection and to notify the physician of changes." Review of the medication administration records (MAR) on December 3, 2010, at 10:30 a.m. reflected that the cold compress treatment was continued until November 23, 2010, ten days after the injury was discovered.</p> <p>On November 23, 2010 at approximately 11:30 a.m., when asked why an incident report was not generated, the RD stated that instructions were given to her by the agency's incident management coordinator that since the injury was a medical concern that no incident report had to be written. Interview with the Registered Nurse (RN) on November 23, 2010, at approximately 11:30 a.m., revealed that she was informed of the blister on November 18, 2010. She assessed Client #1 on the next day, November 17, 2010. The RN stated that the finger was swollen with a dent at the back of the finger. The dented area had a dark discoloration. She informed the PCP of her findings and the physician ordered an x-ray of the finger. The results of the x-ray revealed that the finger was fractured.</p> <p>Further review of the incident report dated November 17, 2010, on November 23, 2010, at approximately 10:00 a.m., revealed that this incident was not reported to the administrator until November 17, 2010, four days after the blister was discovered.</p> <p>The facility failed to report an injury of unknown origin timely.</p>	{W 153}		
{W 158}	<p>483.430 FACILITY STAFFING</p> <p>The facility must ensure that specific facility</p>	{W 158}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 886 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 158)	Continued From page 27 staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the qualified mental retardation professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs of each client [See W158]; failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently [See W188]; and failed to ensure that each staff demonstrated competency in responding to emergency situations involving head injuries [See W192]. The effects of these systemic practices resulted in the facility's failure to provide sufficient number of competent, trained staff to ensure each client's health and safety. 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure each client's adaptive equipment was coordinated and monitored, for six of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include:	(W 158)	W158 1. Cross reference response to W136 1/13/11 2. Cross reference response to W189 12/8/10 3. Cross reference response to W192 1.30.11 4. Cross reference response to W436 12.8.10	1.13.11 12.8.10 1.30.11 12.8.10
(W 158)		(W 158)		

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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 685 1/2 87TH STREET NE WASHINGTON, DC 20019
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{W 159}	Continued From page 28	{W 159}		
	<p>1. [Cross-refer to W136] The QMRP failed to ensure that clients' wheelchairs were operable to enable them to participate in community outings in accordance with their annual plans.</p> <p>2. [Cross-refer to W189] The QMRP facility failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently.</p> <p>3. [Cross-refer to W192] The QMRP failed to ensure that the direct care staff demonstrated competency in employing emergency procedures for clients with head injuries, for the one client who had sustained a documented head injury.</p> <p>4. [Cross-refer to W436] The QMRP failed to ensure that clients' prescribed wheelchairs, air mattresses, shower chairs and/or gurneys were furnished and maintained in good condition, for Clients #1, #2, #3, #4, #5, and #6.</p>			
{W 189}	<p>463.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently, for fifteen of the fifteen staff.</p>	{W 189}		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
805 12 57TH STREET NE
WASHINGTON, DC 20010

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{W 189}	<p>Continued From page 29</p> <p>The findings include:</p> <p>1. All staff were not effectively trained on the facility's newly-instituted administrative directive regarding transportation of clients who utilize wheelchairs for mobility, as indicated by the following:</p> <p>[Cross-refer to W127.4.b and W127.5] After Client #1 died on November 24, 2010, the Governing Body issued a directive to keep a client home if there was a problem with his or her wheelchair. This was again stated on November 29, 2010 upon receiving notice of the immediate jeopardy (IJ), at approximately 8:25 p.m.</p> <p>a. However, on the next morning (November 30, 2010), at 9:20 a.m., Client #4 was observed seated in his wheelchair on the lift mechanism of the facility's van. Observation of his wheelchair at that time revealed that the right anti-tipper was missing and the security straps on both footrests were unattached.</p> <p>b. Upon his return from day program on November 30, 2010, at approximately 4:45 p.m., observation of Client #5's wheelchair revealed that the safety strap on his left foot rest was broken. The client's records indicated that the strap had been broken since at least May 2010.</p> <p>Earlier that morning, at approximately 9:30 a.m., interviews with the direct care staff (at van side) had revealed that they were unaware of the administrative directive to keep a client home if there was a problem with his or her wheelchair. At approximately 10:00 a.m., the QMRP acknowledged that she was aware of the directive and that she had not informed her staff.</p>	{W 189}	<p>W189</p> <p>1. a,b DSP and management staff have been trained on how to follow directives. This training will be repeated annually and on an as needed basis. Staff are aware that no clients should be transported if there wheelchair is not safe.</p> <p>12/8/10, 1/6/11</p>	<p>12.8.10</p> <p>1.6.11</p>

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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 605 1/2 87TH STREET NE WASHINGTON, DC 20019
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{W 189}	<p>Continued From page 30</p> <p>2. The facility failed to ensure that staff were effectively trained on wheelchair safety and monitoring, as follows:</p> <p>[Cross-refer to W127] On November 24, 2010, Client #1 was transported to and from a medical appointment in a wheelchair that did not meet his medical and safety needs. He fell from the wheelchair, sustained a head injury and subsequently died. Staff also had used broken or defective wheelchairs to transport Clients #3, #4, #5 and #6.</p> <p>a. On November 30, 2010, at 2:10 p.m., the residence director (RD) stated that she had recently instructed direct support staff to document the condition of clients' wheelchairs on a "Shift Log/Deployment Sheet" form. Each shift was expected to complete the form. She then presented a signature sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shift Log/Deployment Sheet" and other topics. Review of the signatures failed to show evidence that the three staff who were with Client #1 at the time that he fell had been in attendance. No other documentation was made available for review. At 2:12 p.m., review of Client #1's "Shift Log" sheets for the period November 14, 2010 - November 24, 2010 revealed that staff had not documented any information regarding the condition of his wheelchair, including the broken seat belt buckle.</p> <p>b. On November 30, 2010, at 7:16 p.m., review of the staff in-service training records revealed a Wheelchair Repair Monitoring Form had been developed in 2009. There was a signature sheet indicating that some direct support staff had</p>	{W 189}	<p>2. a,b All DSP staff have been trained on wheelchair safety and monitoring adaptive equipment. QMRP will ensure that before new staff person can work with a client that uses a wheelchair they will be trained on wheelchair safety and monitoring of adaptive equipment.</p> <p>12/8/10</p>	12-8-10

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE
805 1/2 57TH STREET NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 189}	Continued From page 31 received training on that form on October 7, 2009. There was no evidence that facility staff had implemented that monitoring form after the October 7, 2009 training or that staff had received additional training on wheelchair safety and monitoring in the 13 months since October 2009. It should be noted that on November 28, 2010, at 4:00 p.m. the Quality Assurance Specialist/Incident Management Coordinator indicated that he had conducted in-service training regarding transportation and wheelchair safety earlier that same day. He did not, however, provide any documentation of the alleged training when requested. On November 29, 2010, at approximately 7:35 p.m., both the QMRP and the RD agreed to obtain records from their corporate office of any in-service training pertaining to transportation and wheelchair safety. No additional information was made available for review before the investigation ended.	{W 189}		
{W 182}	3. [Cross-refer to W192] The three staff who responded to Client #1's fall on November 24, 2010 had received documented training in first aid. The facility failed to ensure that staff responded appropriately to Client #1's head injury on November 24, 2010. They moved him from the driveway before he had been assessed by a medical professional. 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	{W 192}	3. (Cross reference response to W192). The three staff involved were trained on American Red Cross and had current certifications. Careco Inc. will provide a staff training around response to head injuries. 1/30/11	1-30-11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE

888 1/2 67TH STREET NE

WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 192)	<p>Continued From page 32</p> <p>failed to ensure that all direct support staff (DSS) demonstrated competency in employing emergency procedures for clients with head injuries, for the one client who had sustained a documented head injury. (Client #1)</p> <p>The finding includes:</p> <p>Review of an incident report dated November 24, 2010, on November 28, 2010, at 3:50 p.m., revealed that Client #1 fell from his wheelchair onto a concrete-covered surface in the driveway of the facility and sustained a head injury.</p> <p>Interview with the LPN on November 26, 2010 at approximately 4:00 p.m., revealed that the DSS wheeled Client #1 into the facility and stated that the client fell from his wheelchair after he was transferred from the van. The LPN further stated that he assessed Client #1 and noted "moderate swelling with open area measured at 1 cm x 0.5 cm no depth at the left side of the head close to the left ear. Small drainage of blood with serous drainage."</p> <p>On November 29, 2010, beginning at 11:30 a.m., telephone interviews with the three DSS present at the time of the fall revealed that upon discovering the client on the pavement, they observed that the client had a bump on the side of his head. Staff further indicated that he appeared stunned and confused. The staff immediately picked him up, placed him back into his wheelchair, wheeled him into the facility and then transferred him from the wheelchair into a recliner, where he was subsequently evaluated by a nurse. Their interviews also indicated that they had received current training on first aid.</p>	(W 192)	<p>W192</p> <p>This STANDARD will be met as follows:</p> <p>The three staff involved was trained on American Red Cross and had current certifications. Careco, Inc. will provide a staff in-service training around response to head injuries.</p> <p>1/30/11</p>	1-30-11

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WASHINGTON, DC 20010

[W 192]

Continued From page 33

On November 30, 2010, at 11:00 a.m., review of the in-service training records maintained by the facility revealed documented evidence verifying that the three DSS indeed had current first aid certification. On December 3, 2010, at 12:30 p.m., review of the American Red Cross's website confirmed that a person who sustains a head injury should not be moved unless there is "further danger." Staff failed to demonstrate an effective response to Client #1's emergency situation.

[W 331]

483.480(c) NURSING SERVICES

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility's nursing staff failed to ensure verbal orders were transcribed onto a physician's order sheet (POs), for one of seven clients in the facility.
(Client #1)

The finding includes:

Review of the direct support staff (DSS) documentation dated November 13, 2010, on December 3, 2010, at 10:00 a.m., revealed that the DSS observed Client #1 reportedly had no pain on his right index finger and reported their observation to the nurse on November 13, 2010. On November 23, 2010, at approximately 10:20 a.m., review of the a corresponding nursing note dated November 13, 2010, revealed that the client's right index finger was swollen with a blister to the lower part of the finger. The nurse applied a cold compress to his finger. The nurse

[W 192]

{W 331}

W331

This STANDARD will be met as follows:

The Nurses will be trained by the RN Supervisor on documenting Physician's orders.

1/30/11

W436

This STANDARD will be met as follows:

Cross reference response to W127

1. Cross reference response to W127.1

12/8/10

2. Cross reference response to W127.2

12/8/10

3. Cross reference response to
W127.3

12/8/10

4. Cross reference response to W127.4

12/8/10

5. Cross reference response to W127.5

11/1/10

6. Cross reference response to W127.6

12/13/10

**COMPLETION
DATE**

1-30-11

12.8.10

44-10

12.13.10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0321

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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE
606 1/2 67TH STREET NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 34 notified the primary care physician (PCP) and was ordered to apply a cold compress twice a day until resolved and to monitor for infection and to notify the physician of any changes. Review of the medication administration records (MAR) on December 3, 2010, at 10:30 a.m., reflected that the cold compress treatment was continued until November 23, 2010; however, review of the POs failed to show evidence that the nurse documented the order on the order sheet for the physician's signature.	{W 331}		
{W 436}	463.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the health and safety of each client by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, shower chairs and/or gurneys) as prescribed and/or provided transportation services, for four of the six clients currently residing in the facility. (Clients #2, #3, #4 and #5) The findings include: Cross-refer to W127. On December 15, 2010, Client #2's newly-delivered custom molded gurney wheelchair had not been assessed by the	{W 436}		

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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE

806 12 67TH STREET NE

WASHINGTON, DC 20010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 438}	<p>Continued From page 35</p> <p>physical therapist and the facility had not secured transportation for him to access outside medical services. Client #3 remained without the prescribed shower gurney and custom molded wheelchair. His loaner wheelchair was inoperable on the day before, which led to his missing two medical appointments. Staff were observed moving Client #4 without putting the anti-tippers on his wheelchair in the down position, to ensure his safety. Client #5 remained without a shower gurney stretcher, and there was no evidence presented that the QMRP had brought the occupational therapist's November 1, 2010 recommendation for a shower gurney stretcher to the PCP's attention.</p> <p>Previously, the Federal Deficiency Report dated December 3, 2010, included the following:</p> <p>1. [Cross-refer to W127.1] The facility failed to obtain a custom molded wheelchair for Client #1. According to staff, the seat belt on the wheelchair the client was using on the day that he fell (November 24, 2010) had been broken for "approximately 30 days" prior to the incident. On November 29, 2010, at 7:00 p.m., observation of the wheelchair revealed that the seat belt was indeed broken. In addition, the padding on the right arm rest was completely gone (the metal frame of the arm rest was exposed).</p> <p>Problems with Clients #1's wheelchair were previously cited in an HRLA recertification deficiency report dated August 20, 2010. There was no evidence that the governing body implemented their Plan of Correction since it was submitted on September 23, 2010. The</p>	{W 438}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 5TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 436)	<p>Continued From page 36</p> <p>wheelchair had not been repaired, the QMRP had not maintained running notes in Client #1's records, and there was no evidence of quality assurance (QA) monitoring since the August 20, 2010 survey.</p> <p>2. [Cross-refer to W127.2] Client #2 was admitted to this facility on September 7, 2010 with a broken hospital bed was broken (the head could not be elevated). It remained broken for an 83 day period between September 7, 2010 - November 29, 2010. His custom molded gurney wheelchair broke on September 25, 2010. Since then, he had been confined to a hospital bed and had not left the facility. This led to several missed medical appointments. In addition, Client #2 had received bed baths since his September 7, 2010 admission due to the facility's failure to obtain a shower gurney.</p> <p>3. [Cross-refer to W127.3] Client #3 was admitted to the facility on August 5, 2010 with a recommendation that he receive a custom molded wheelchair. As of November 30, 2010, the client was without a custom molded wheelchair. The client's PCP wrote an order for a "rolling shower commode chair" on September 28, 2010. As of November 30, 2010, the client was without a rolling shower commode chair. In addition, the client's records showed that it took the facility almost three months to obtain an air mattress.</p> <p>4. [Cross-refer to W127.4] The facility failed to maintain Client #4's wheelchair. In an HRLA recertification deficiency report dated August 20, 2010, the facility was cited for Client #4's wheelchair having "two different types of wheels ... rear left wheel was observed to have ridges in</p>	(W 436)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00G224	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R-C 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 685 1/2 57TH STREET NE WASHINGTON, DC 20019
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(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
{W 436}	<p>Continued From page 37</p> <p>the tire while the right rear was observed to have a smooth tire." In their Plan of Correction (PoC), dated September 23, 2010, the facility stated that the "QMRF will contact the equipment vendor and have the chair repaired. The QMRF will maintain a log of contacts with the equipment vendor and follow-up to ensure that the repairs are effectuated as soon as possible," and "the QA will monitor for three months to ensure compliance." Review of Client #4's record, however, failed to show evidence that the facility had implemented the POC. The wheelchair had not been repaired and in addition to the previously identified repairs needed (mismatched wheels), the right anti-tipper was missing and the safety straps on both foot rests were unattached. As of November 30, 2010, the vendor still needed to take measurements and the client would be without an appropriate wheelchair for another 30 days.</p> <p>5. [Cross-refer to W127.5] The facility failed to repair the broken safety strap on the left footrest of Client #6's wheelchair, and failed to order a shower gurney that was recommended by the OT four weeks earlier.</p> <p>6. [Cross-refer to W127.6] The facility failed to repair or replace the broken right footrest on Client #6's wheelchair in the six months since the OT identified the need on May 12, 2010.</p>	{W 436}		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(1 000)	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on December 15, 2010 to verify that the Group Home for Persons with Intellectual Disabilities (GHPID) had implemented their plan (submitted December 14, 2010) to resolve an Immediate Jeopardy (IJ) that was found to exist on November 29, 2010. Through observations of the residents and their adaptive equipment, interviews with direct support, nursing and administrative staff as well as a review of the residents' records, the determination was made that the facility had not taken sufficient corrective action to remove the IJ. Specifically, the facility failed to provide transportation services and/or necessary adaptive mobility equipment to ensure that two (out of six) residents received outside medical services. [See 1500]</p> <p>Previously, on November 24, 2010, at approximately 6:24 p.m., the Health Regulation and Licensing Administration's (HRLA), Compliance and Quality Assurance Investigation Division (CQAID) was notified by voicemail of the death of Resident #1. According to the message, the resident fell from his wheelchair, sustained a head injury and subsequently died while at the hospital. On November 28, 2010, the CQAID initiated an investigation to determine the facility's compliance with both Federal participation and local licensure requirements for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFID) participating in the Medicaid program.</p> <p>On November 29, 2010, the Intermediate Care Facilities Division (ICFD) received a complaint from the Department on Disability Services that</p>	(1 000)		

Health Regulation Administration

Jeffery D. Senko Interim Director of Disability Services

LICENSURE DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORN

(X6) DATE

1/7/11

PCT812

If continuation sheet 1 of 30

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 605 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{1 000}	<p>Continued From page 1</p> <p>alleged residents in the facility did not have necessary adaptive equipment. The complaint further alleged that needed medical services were not being provided and the facility failed to implement dietary orders and mealtime protocols as required. A monitoring visit/investigation was initiated by the ICFD into the following allegations on November 29, 2010:</p> <ol style="list-style-type: none"> 1. Resident #2's "wheelchair gurney" was reported by his occupational therapist (OT) as broken beyond repair. Allegation was substantiated. 2. Resident #2's scheduled medical follow up appointments, i.e., his annual ophthalmology follow up for glaucoma and annual urology, have been cancelled due to "transportation" issues related to his wheelchair gurney. Allegation was substantiated 3. Resident #2's labs ordered by his primary physician on September 1, 2010, have not been completed. The nurse stated that the labs have not been completed due to the "transportation" issues. Allegation was substantiated 4. Resident #2 is prescribed a low fat, low cholesterol pureed diet with nectar thickened liquids. On the date of the review, November 23, 2010, Resident #2's liquids were not presented in accordance to his prescribed diet and texture. He was provided "boost" liquid which was not thickened. Allegation was not substantiated 5. Resident #2 has a mealtime positioning plan to address his risk of aspiration and choking. His plan includes elevating the head of his bed to a 	{1 000}		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019
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(1 000)	<p>Continued From page 2</p> <p>20 degree angle and the using a positioning wedge to elevate the resident an additional 50 degrees during and following his mealtime. On the date of the review, he was not properly positioned during his mealtime as recommended. Allegation was not substantiated</p> <p>6. The home has no system in place by which to monitor Resident #2's weight. A wheelchair scale is in the home but is not currently operational. Allegation was substantiated</p> <p>7. Although the nurse and Qualified Mental Retardation Professional (QMRP) are aware that Resident #2's weight is not being obtained or monitored, there is lack of monitoring of Resident #2's food intake. Allegation was partially substantiated</p> <p>8. The facility does not have a positioning plan in place to address Resident #2's skin integrity. Allegation was substantiated</p> <p>9. The facility was not monitoring/documenting Resident #2's bowel movements. Allegation was not substantiated</p> <p>The findings of the monitoring visit/investigation were based on observations at the group home, interviews, and the review of clinical and administrative records, including incident reports. Six of the seven residents currently residing in the facility were reviewed. One additional resident's records was reviewed for the death investigation. The results of the monitoring visit/investigation revealed that conditions found, posed an immediate and serious threat to the health and safety of residents residing at the</p>	(1 000)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 885 1/2 57TH STREET NE WASHINGTON, DC 20019
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(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
(I 000)	Continued From page 3 facility. On November 29, 2010, at approximately 6:25 p.m. the Director of Developmental Disabilities Services (DDDS) was notified that an immediate Jeopardy (IJ) existed at the facility. At that time, the DDS submitted a plan to resolve the IJ, however the plan was not accepted by the State Agency. Note: On November 23, 2010, an investigation was initiated on Resident #1. An incident report dated November 17, 2010, reflected that Resident 1's right index finger was fractured. The cause of the injury was unknown. It should further be noted that the investigation was not completed due to the death of Resident #1. This report includes deficiencies from the preliminary investigation into this incident.	(I 000)		
(I 100)	3507.1 POLICIES AND PROCEDURES Each GHPID shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to implement a policy and procedure manual that was detailed and outlined policies to meet each residents needs, for six of the seven residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include:	(I 100)		12.17.10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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{ 160 }	Continued From page 4 1. [Cross-refer to I500] The facility failed to ensure the health and safety of each resident by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, air mattresses, shower chairs and/or gurneys) as prescribed, for Residents #1, #2, #3, #4, #5 and #6. 2. Staff failed to implement the facility's transportation policy, as follows: On November 30, 2010, at 9:45 a.m., a driver left the facility with Resident #5 to take him to day program. There was no other person observed on the van (no attendant). At 10:16 a.m., interview with the residence director (RD) revealed that the facility's policy was to have at least one other staff person on the van when they drove residents in the community. She explained, however, that they were short of staff that morning and that Resident #5 usually did not exhibit significant behaviors. Later that day, at approximately 7:25 p.m., review of the facility's transportation policy, dated 2007, revealed Policy B.1.b. "When individuals are transported, an attendant (a person other than the driver) is assigned to accompany them to attend to their special needs." 3. [Cross-refer to I379] Facility staff failed to report an injury of unknown origin (Resident #1's finger swollen, later determined to be broken) timely, in accordance with the facility's incident management policies. On November 23, 2010, beginning at approximately 1:00 p.m., review of the facility's incident management policy revealed that injuries of unknown origin were categorized as a serious reportable incident. The policy specifies that serious reportable	{ 160 }	<p>I160 This STATUTE will be met as follows:</p> <ol style="list-style-type: none"> Staff has been in-serviced on Careco Inc, Adaptive Equipment Policy and Procedures and Adaptive Equipment Protocol. 12/17/10 Staff will be in-serviced on Careco Inc. Transportation Policy. Henceforth staff will be expected to have an attendant in the van when clients are being transported. <p>3. Cross reference response to Federal deficiency W153 12/1/10</p>	<p>12.17.10</p> <p>1.6.10</p> <p>12.1.10</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 605 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 160)	Continued From page 5 incidents are to be reported to the immediate supervisor or manager and an incident report generated. There was no documented evidence that the staff (direct support and nursing) implemented the incident management policy as outlined.	(I 160)		
(I 180)	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Persons with Intellectual Disabilities (GHPID)'s qualified mental retardation professional (QMRP) failed to ensure each resident's adaptive equipment was coordinated and monitored, for six of seven residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. [Cross-refer to I449] The QMRP failed to ensure that residents' wheelchairs were operable to enable them to participate in community outings in accordance with their annual plans. 2. [Cross-refer to I228] The QMRP facility failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently. 3. [Cross-refer to I500] The QMRP failed to	(I 180)	I180 This STATUTE will be met as follows: 1. Cross reference response to I449 12/8/10 2. Cross reference response to I228 12/8/10 3. Cross reference response to I500	12.8.10 12.8.10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 180)	Continued From page 6 ensure that residents' prescribed wheelchairs, air mattresses, shower chairs and/or gurneys were furnished and maintained in good condition, for Residents #1, #2, #3, #4, #5, and #6.	(I 180)		
(I 228)	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observations, interview, and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently, for fifteen of the fifteen staff. The findings include: 1. All staff were not effectively trained on the GHPID's newly-instituted administrative directive regarding transportation of residents who utilize wheelchairs for mobility, as indicated by the following: [Cross-refer to I500.4 and I500.5] After Resident #1 died on November 24, 2010, the governing body issued a directive to keep a resident home if there was a problem with his or her wheelchair. This was again stated on November 29, 2010 upon receiving notice of the immediate jeopardy (IJ), at approximately 6:25 p.m. a. However, on the next morning (November 30, 2010), at 9:20 a.m., Resident #4 was observed	(I 228)	I228 This STATUTE will be met as follows: 1. a,b Staff have been in serviced on the Transportation policy to ensure safety and rights of clients are maintained. Additional training was provided to all staff on following written and verbal directives. 12/8/10 2. a-c Cross reference response to I500 and cross reference response to Federal Deficiency W189.2 12/8/10 3. See Response to Federal Deficiency W192 1/6/11	12-8-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 806 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{1 228}	<p>Continued From page 7</p> <p>seated in his wheelchair on the lift mechanism of the facility's van. Observation of his wheelchair at that time revealed that the right anti-tipper was missing and the security straps on both footrests were unattached.</p> <p>b. Upon his return from day program on November 30, 2010, at approximately 4:45 p.m., observation of Resident #5's wheelchair revealed that the safety strap on his left foot rest was broken. The resident's records indicated that the strap had been broken since at least May 2010. Staff, however, had transported him to day program earlier that day with the wheelchair in that condition.</p> <p>Earlier that morning, at approximately 9:30 a.m., interviews with the direct care staff (at van side) had revealed that they were unaware of the administrative directive to keep a resident home if there was a problem with his or her wheelchair. At approximately 10:00 a.m., the QMRP acknowledged that she was aware of the directive and that she had not informed her staff.</p> <p>2. The facility failed to ensure that staff were effectively trained on wheelchair safety and monitoring, as follows:</p> <p>[Cross-refer to I500] On November 24, 2010, Resident #1 was transported to and from a medical appointment in a wheelchair that did not meet his medical and safety needs. He fell from the wheelchair, sustained a head injury and subsequently died. Staff also had used broken or defective wheelchairs to transport Residents #3, #4, #5 and #6.</p> <p>a. On November 30, 2010, at 2:10 p.m., the residence director (RD) stated that she had</p>	{1 228}		12.8.10

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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 506 1/2 57TH STREET NE WASHINGTON, DC 20019
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{1 228}	<p>Continued From page 8</p> <p>recently instructed direct support staff to document the condition of residents' wheelchairs on a "Shift Log/Deployment Sheet" form. Each shift was expected to complete the form. She then presented a signature sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shift Log/Deployment Sheet" and other topics. Review of the signatures failed to show evidence that the three staff who were with Resident #1 at the time that he fell had been in attendance. No other documentation was made available for review. At 2:12 p.m., review of Resident #1's "Shift Log" sheets for the period November 14, 2010 - November 24, 2010 revealed that staff had not documented any information regarding the condition of his wheelchair, including the broken seat belt buckle.</p> <p>b. On November 30, 2010, at 7:18 p.m., review of the staff in-service training records revealed a Wheelchair Repair Monitoring Form had been developed in 2009. There was a signature sheet indicating that some direct support staff had received training on that form on October 7, 2009. There was no evidence that facility staff had implemented that monitoring form after the October 7, 2009 training or that staff had received additional training on wheelchair safety and monitoring in the 13 months since October 2009. It should be noted that on November 28, 2010, at 4:00 p.m. the Quality Assurance Specialist/Incident Management Coordinator indicated that he had conducted in-service training regarding transportation and wheelchair safety earlier that same day. He did not, however, provide any documentation of the alleged training when requested. On November 29, 2010, at approximately 7:35 p.m., both the QMRP and the RD agreed to obtain records from their corporate office of any in-service training</p>	{1 228}		

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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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(I 228)	Continued From page 9 pertaining to transportation and wheelchair safety. No additional information was made available for review before the investigation ended. 3. [Cross-refer to Federal Deficiency Report - Citation W192] The three staff who responded to Resident #1's fall on November 24, 2010 had received documented training in first aid. The facility failed to ensure that staff responded appropriately to Resident #1's head injury on November 24, 2010. They moved him from the driveway before he had been assessed by a medical professional.	(I 228)		1-6-11
(I 379)	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all unusual incidents that place a resident's health and welfare at risk were reported immediately to the Department of Health, for one of the seven residents of the facility. (Resident #1)	(I 379)	1379 This STATUTE will be met as follows: Cross reference response to Federal Deficiency W153 12/1/10	12-1-10

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{1 379}	<p>Continued From page 10</p> <p>The finding includes:</p> <p>The Department of Health was notified on November 17, 2010 via facsimile of an injury of unknown origin to Resident #1's finger. According to the incident report, Resident #1 sustained a fracture to his right pointer (index) finger. The cause of the fracture was not noted on the incident report. An on-site investigation was initiated on November 23, 2010. Interview with the residence director (RD) on November 23, 2010, at approximately 10:30 a.m., revealed that when the incident was discovered on November 13, 2010, the resident had a blister on his finger (origin was unknown). The corresponding nursing note dated November 13, 2010, acknowledged the staff's notification and noted that the pointer (index) finger of the right hand was swollen with a blister to the lower part of the finger close to the palm. The finger reportedly was not painful to touch and a cold compress was applied. The primary care physician (PCP) was notified. The PCP ordered to "continue with the cold compresses twice a day until resolved and to monitor for infection and to notify the physician of changes." Review of the medication administration records (MAR) on December 3, 2010, at 10:30 a.m. reflected that the cold compress treatment was continued until November 23, 2010, ten days after the injury was discovered.</p> <p>On November 23, 2010 at approximately 11:30 a.m., when asked why an incident report was not generated, the RD stated that instructions were given to her by the agency's incident management coordinator that since the injury was a medical concern that no incident report had to be written. Interview with the Registered</p>	{1 379}		

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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019
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(I 379)	<p>Continued From page 11</p> <p>Nurse (RN) on November 23, 2010, at approximately 11:30 a.m., revealed that she was informed of the blister on November 16, 2010. She assessed Resident #1 on the next day, November 17, 2010. The RN stated that the finger was swollen with a dent at the back of the finger. The dented area had a dark discoloration. She informed the PCP of her findings and the physician ordered an x-ray of the finger. The results of the x-ray revealed that the finger was fractured.</p> <p>Further review of the incident report dated November 17, 2010, on November 23, 2010, at approximately 10:00 a.m., revealed that this incident was not reported to the administrator until November 17, 2010, four days after the blister was discovered.</p> <p>The facility failed to report an injury of unknown origin timely.</p>	(I 379)		
(I 449)	<p>3521.7(s) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHPID shall include, when appropriate, but not be limited to, the following areas:</p> <p>(s) Opportunity for social, recreational and religious activities utilizing community resources.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents participated in community outings in accordance with their annual plans, for two of the seven residents of the facility. (Residents #2 and #3)</p>	(I 449)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/16/2010
NAME OF PROVIDER OR SUPPLIER CARECO		STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
(I 449)	<p>Continued From page 12</p> <p>The findings include:</p> <p>1. [Cross-refer to I500.2]. Resident #2 was admitted to this facility on September 7, 2010. On November 29, 2010, at 3:50 p.m., Resident #2's custom molded gurney wheelchair was observed being stored in a supply room. It was tilted to one side and the evening nurse explained that the frame was broken. Simultaneous interviews with the qualified mental retardation professional (QMRP) and residence director (RD) later that evening, at 7:12 p.m., revealed that the resident's gurney wheelchair had been functioning properly when he was admitted. The gurney wheelchair broke, however, on September 25, 2010. They indicated that the gurney wheelchair was assessed, and the QMRP presented her progress note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." As of November 30, 2010, Resident #2 remained without a custom molded gurney wheelchair and was confined to the hospital bed, within the facility.</p> <p>On November 30, 2010, beginning at 6:00 p.m., review of Resident #2's medical records revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and lipid profile." At 7:00 p.m., the QMRP confirmed that the resident</p>	(I 449)	<p>I449 This STATUTE will be met as follows: 1. Cross reference response to I500.2 and Federal Deficiency W127.2 12/8/10</p>		12-8-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 508 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 440)	Continued From page 13 had missed his ophthalmology and urology appointments due to the lack of a gurney wheelchair. Since being confined to the hospital bed, Resident #2 had not left the facility and, therefore, his community integration was restricted. It should be noted that his Individual Support Plan (ISP) dated November 9, 2009, indicated that "going to my day program and community outings" were what was most important to him. The ISP also included "It is important that I maintain optimal health, maintain a wheelchair that is in good repair and good relationships." 2. [Cross-refer to I500.3]. On November 29, 2010, at 3:45 p.m., the left armrest on Resident #3's wheelchair was observed to be detached. Interview with the evening licensed practical nurse (LPN) revealed that the wheelchair had "recently" broken. The detached armrest had white adhesive tape wrapped around the bottom of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. As of November 30, 2010, the resident had been without a functioning wheelchair for approximately one week and, therefore, confined to the interior of the GHPID.	(I 440)		
(I 500)	3523.1 RESIDENT'S RIGHTS Each GHPID residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	(I 500)	2. Cross reference response to I500.2 and Federal Deficiency W127.3 12/8/10	12/8/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20010
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	Continued From page 14 This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the health and safety of each resident by making certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, shower chairs and/or gurneys) as prescribed and/or provided transportation services, for four of the six residents currently residing in the facility. (Residents #2, #3, #4 and #5) The findings include: 1. On December 15, 2010, at 8:00 a.m., Resident #2 remained without transportation to facilitate outside medical services, as evidenced below: a. Resident #2 was observed in his hospital bed when the visit began, at 7:48 a.m. At 12:30 p.m., a new custom molded gurney wheelchair was delivered to the facility by the wheelchair vendor. However, interview with the Interim Director of Developmental Services (IDS) revealed that the physical therapist (PT) would first need to assess the new gurney wheelchair to verify that it meets Resident #2's specific needs. As of 5:33 p.m., the facility had not secured an appointment with the PT. At 5:25 p.m., interview with the facility's quality assurance (QA) specialist revealed that he had just taken measurements of Resident #2's new gurney wheelchair. He questioned whether the vehicle previously-identified for transporting the resident would be able to accommodate the wheelchair. He further indicated that he would	(I 500)	1500 1. a-c Cross reference response to Federal Deficiency W127.2	12-8-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019
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(I 500)	<p>Continued From page 15</p> <p>have his "specialist" examine the vehicle and determine whether the facility would need to order additional tie down straps.</p> <p>In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated, "arrangements have been made with <transportation vendor> to transport Resident #2 to medical appointments in the absence of his wheelchair." At 1:40 p.m., interview with registered nurse (RN) revealed that an application form for such services had been transmitted via facsimile to the transportation vendor on the day before (December 14, 2010). According to the DDS, at 3:25 p.m., the application process required 24-48 hours to determine his eligibility for services. Moments later, review of the application form verified that it had indeed been dated December 14, 2010. At approximately 4:30 p.m., Resident #2's Service Coordinator with the Department of Disability Services (DDS) introduced herself to the survey team. She stated that the transportation vendor previously identified by the facility had informed her approximately one week earlier that they did not transport residents who reside in intermediate care facilities (ICFs). At 4:50 p.m., during a teleconference with the facility's administrator and the state agency, the DDS acknowledged that to date, no alternative transportation services had been sought.</p> <p>b. On December 15, 2010, at 10:15 a.m., review of Resident #2's medical record revealed a lab report indicating that serum and urine samples had been obtained on December 9, 2010. The lab report showed several abnormal readings including a high serum level for cholin. Moments later, review of a nurse progress note dated December 13, 2010 revealed that a</p>	(I 500)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 67TH STREET NE WASHINGTON, DC 20019
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{1 500}	<p>Continued From page 16</p> <p>licensed practical nurse (LPN) had reviewed the lab results and had left a message on the primary care physician's (PCP) telephone service that day. On December 14, 2010, the same LPN documented the PCP's telephone order to decrease Resident #2's dilantin and to retest his dilantin levels on December 16, 2010. At 11:46 a.m., the LPN stated that a nurse would come to the facility the next day (December 16, 2010) to obtain new serum and urine samples.</p> <p>At approximately 4:45 p.m., interview with the DDS and the DDS Service Coordinator revealed that Resident #2 had continued missing medical appointments due to the lack of transportation. Previously, the resident had an ophthalmology appointment rescheduled from November 5, 2010 to December 2, 2010. He did not, however, make it to the December 2, 2010 appointment. Similarly, he missed a December 10, 2010 urology appointment which had originally been scheduled for November 9, 2010. As of December 15, 2010, Resident #2 remained without transportation services and was, therefore, not receiving medical services outside of the facility.</p> <p>c. It should be noted that on December 15, 2010, Resident #2 remained without a shower gurney, two months after it was ordered by the PCP. At 9:45 a.m., interview with the DDS revealed that a second 719A form had been submitted for the shower gurney. She presented a 719A form that was signed by the PCP on November 30, 2010. Moments later, review of the resident's qualified mental retardation professional (QMFP) progress note on adaptive equipment, dated December 13, 2010, failed to reflect the status of the shower gurney. In the meantime, the PCP wrote an order on December 8, 2010, for Resident #2</p>	{1 500}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	<p>Continued From page 17</p> <p>to continue receiving bed baths while awaiting the shower gurney.</p> <p>2. The facility failed to maintain Resident #3's wheelchair to ensure that he received outside medical services, as evidenced below:</p> <p>a. On December 15, 2010, from 7:46 a.m. until 12:45 p.m., Resident #3 was observed in his hospital bed. At 12:30 p.m., the wheelchair vendor arrived in the facility and repaired the safety belt on the resident's wheelchair. At 12:43 p.m., interview with the LPN revealed that on the day before (December 14, 2010), Resident #3's wheelchair seatbelt had been loose on the right side; the wheelchair was deemed unsafe. The nurse further indicated that because the seatbelt could not be secured properly, the resident had missed two medical appointments (wound care clinic and PCP) that were scheduled for December 14, 2010.</p> <p>At approximately 1:45 p.m., interview with the RD and IDDS revealed that the same seatbelt on the loaner wheelchair had been repaired previously, on December 8, 2010. Then on the morning of December 14, 2010, "the other side" of the seatbelt had "come loose." During the exit conference, at 5:00 p.m., the IDDS acknowledged that the facility had not made another wheelchair available for Resident #3 on the previous day, to ensure that he kept his appointments.</p> <p>b. In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated the QMRP was "following the Medicare process for obtaining a custom molded wheelchair for Resident #3. <Wheelchair vendor> had indicated that</p>	(I 500)	<div style="border: 1px solid black; padding: 5px; margin: 10px;"> <p style="text-align: right;">12/8/10</p> <p>2. a,b Cross reference response to Federal Deficiency W127.3</p> <p style="text-align: right;">12/8/10</p> </div>	12-8-10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	<p>Continued From page 18</p> <p>Medicare is requesting face-to-face visit with his <PCP> before they will authorized payment for ... new wheelchair." At approximately 4:00 p.m., interview with the LPN revealed that Resident #3 had not had a "face-to-face" visit with the PCP. The PCP, however, wrote a prescription for Resident #3 to receive a custom made wheelchair and a rolling shower chair/commode with waist belt. She presented the prescription and corresponding consultation form, which had both been signed and dated December 14, 2010 by the PCP. At approximately 4:10 p.m., follow-up interview with the RN and the same LPN again revealed that the resident was not seen by the PCP on December 14, 2010. They further explained that the PCP "sees him frequently."</p> <p>3. On December 15, 2010, at 8:37 a.m., Resident #4 was observed seated in his wheelchair. The wheelchair's anti-tippers were in the up position. Interview with a direct support staff who was working with the resident indicated that the anti-tippers were used to help support the wheelchair from tipping backwards, when going up a hill. The staff did not, however, state how the anti-tippers should be positioned. At 9:07 a.m., the staff was observed propelling the resident toward the door. The anti-tippers were still in the up position. At 9:15 a.m., the RD was observed pushing Resident #4 outside towards the van. Again, the anti-tippers remained in the up position. When brought to her attention a few moments later, the DDS acknowledged that the anti-tippers were in the up position. She (DDS) then intervened and instructed the staff to reposition the anti-tippers in order for them to be effective. The RD and direct support staff subsequently adjusted the anti-tippers to the down position to ensure the resident's safety.</p>	(I 500)	<p>3. Cross reference response to Federal Deficiency W127.4 12/8/10</p>	12-8-10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 565 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	Continued From page 19 When interviewed by telephone at 8:50 a.m., the wheelchair vendor stated "the anti-tippers should be in the down position whenever the wheelchair is moving." It should be noted that review of the staff in-service records, at approximately 2:30 p.m., revealed that on December 8, 2010, facility staff had received training on safety and positioning in wheelchairs. Observations on the morning of December 15, 2010, however, indicated that the training had not been effective. 4. In the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated that Resident #5's wheelchair had been repaired and was in safe working condition. The response letter did not reflect the recommended shower gurney stretcher for bathing. On December 15, 2010, at 8:20 a.m., inspection of the resident's wheelchair confirmed that the safety strap on the left footrest had indeed been repaired. The resident, however, remained without a shower gurney stretcher, and there was no evidence presented that the QMRP had brought the occupational therapist's November 1, 2010 recommendation for a shower gurney stretcher to the PCP's attention. Previously, the Licensure Deficiency Report dated December 3, 2010, included the following: 1. Resident #1, who died from head injuries sustained in a fall from his wheelchair on November 24, 2010, was admitted to the GHPID in July 2008. a. On November 29, 2010, at approximately 6:10 p.m., interview with the qualified mental	(I 500)	4. Cross reference response to Federal Deficiency W127.5 11/1/10 1500 Federal Deficiency Report 12/3/10 1. a-e Cross reference response to Federal Deficiency W127.1 12/8/10	11.1.10 12.8.10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	<p>Continued From page 20</p> <p>retardation professional (QMRP) revealed that Resident #1 had initially been admitted with a custom molded wheelchair. The wheelchair, however, allegedly was repossessed by the wheelchair vendor shortly thereafter, due to problems with the payment. [Note: The QMRP was unsure of the actual date and review of the resident's record later that evening failed to identify the exact date on which his custom molded wheelchair was removed from the facility.] Further interview with the QMRP revealed that in December 2009, the facility enlisted the support of the resident's attorney in an effort to secure a custom molded wheelchair that Resident #1 allegedly had been using while residing with a former provider. Those efforts, however, failed and the QMRP acknowledged that the facility had not initiated the formal process towards obtaining a new custom molded wheelchair.</p> <p>b. On November 30, 2010, beginning at 10:00 a.m., review of Resident #1's physical therapy (PT) records revealed ongoing recommendations to obtain a custom molded wheelchair. His annual PT evaluation, dated September 22, 2008, included "consider a custom molded seating system." Then on October 13, 2008, the PT documented that the standard wheelchair, with sling type seating (the one the resident was using at that time of his death) was inappropriate. He wrote "He sits on his right ilium. His trunk is shifted right. There is increased pressure on his right axilla from the right arm rest. The seating system perpetuates his scoliosis and deformities. He is at risk of skin breakdown." The PT again recommended a custom molded wheelchair. In the next annual evaluation, dated October 15, 2009, the PT wrote the resident "had not received the</p>	(I 500)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R 12/15/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20019
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(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETE DATE
(I 500)	<p>Continued From page 21</p> <p>appropriate wheelchair" and recommended "Follow-up with new custom wheelchair." On October 4, 2010, the PT performed another annual evaluation at which time he repeated the same recommendation for a custom molded wheelchair. The governing body failed to address the recommendations for a custom molded wheelchair.</p> <p>c. Similarly, review of Resident #1's occupational therapy (OT) records on November 30, 2010, beginning at 10:15 a.m. revealed that the OT had repeatedly documented that the resident's wheelchair did not meet his needs. An OT evaluation dated September 14, 2009, included "the wheelchair is wide and the seat and back do not provide good support. He is at great risk for falls and skin breakdown in this chair. A new wheelchair evaluation and new wheelchair are strongly recommended ..." The resident's most recent OT Evaluation, dated September 11, 2010, recommended a wheelchair assessment and a new wheelchair. On November 1, 2010, the OT again noted that the standard wheelchair "does not provide optimal balance, posture, or positioning." Later that month, the resident died after sustaining a head injury.</p> <p>d. On November 29, 2010, at 11:30 a.m., telephone interview with the direct support staff person who had assisted Resident #1 out from the van and onto the lift on the day that he fell (November 24, 2010), revealed that the buckle on the seat belt of his wheelchair had been broken for "approximately 30 days." There was no evidence, however, that the facility attempted to have the seat belt repaired. On November 29, 2010, at 7:00 p.m., observation of the wheelchair revealed that the seat belt was indeed broken. In addition, the padding on the right arm rest was</p>	(I 500)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{1 500}	<p>Continued From page 22</p> <p>completely gone (the metal frame of the arm rest was exposed).</p> <p>e. Problems with Resident #1 wheelchair were previously cited in an HRLA recertification deficiency report dated August 20, 2010. There was no evidence, however, that the governing body implemented their Plan of Correction (PoC) since it was submitted on September 23, 2010. The QMRP had not maintained running notes in Resident #1's records regarding needed repairs and there was no evidence of quality assurance (QA) monitoring since the August 20, 2010 survey.</p> <p>2. Resident #2 was admitted to this GHPID on September 7, 2010. Resident #2 did not receive new adaptive equipment as prescribed (gurney wheelchair, shower gurney), and/or timely repairs to his existing adaptive equipment, as evidenced below:</p> <p>a. On November 29, 2010, at 3:45 p.m., a repairman was observed working on a hospital bed located in a back bedroom. The evening licensed practical nurse (LPN) indicated that the head of this hospital bed, which belonged to Resident #2, could not be elevated. At 4:23 p.m., the LPN informed surveyors that the head of the hospital bed was now operating, which he then demonstrated successfully. At approximately 7:15 p.m., interview with the residence director (RD) revealed that the head of Resident #2's hospital bed could not be elevated for the 83 days since he was admitted to the GHPID, on September 7, 2010.</p> <p>b. On November 29, 2010, at 3:50 p.m., Resident #2's custom molded gurney wheelchair was observed being stored in a supply room. It</p>	{1 500}	<p>2. a-d Cross reference response to Federal Deficiency W127.2</p> <p>12/8/10</p>	12-8-10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 808 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{1 500}	<p>Continued From page 23</p> <p>was tilted to one side and the evening nurse explained that the frame was broken. Simultaneous interviews with the QMRP and RD later that evening, at 7:12 p.m., revealed that the resident's gurney wheelchair had been functioning properly when he was admitted. The gurney wheelchair broke, however, on September 25, 2010. They indicated that the gurney wheelchair was assessed, and the QMRP presented her progress note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." As of November 30, 2010, Resident #2 remained without a custom molded gurney wheelchair and was confined to the hospital bed, within the facility.</p> <p>c. On November 30, 2010, beginning at 6:00 p.m., review of Resident #2's medical records revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and lipid profile." At 7:00 p.m., the QMRP confirmed that the resident had missed his ophthalmology and urology appointments due to the lack of a gurney wheelchair. [Note: The appointments had been rescheduled for December 2010.] As of that evening, however, there was no finalized plan for obtaining the laboratory studies ordered on October 1, 2010. Since being confined to the hospital bed, Resident #2 had not left the GHPID and, therefore, his community integration was</p>	{1 500}		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/18/2010
NAME OF PROVIDER OR SUPPLIER CARECO			STREET ADDRESS, CITY, STATE, ZIP CODE 805 1/2 57TH STREET NE WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 500)	<p>Continued From page 24</p> <p>restricted. It should be noted that his individual Support Plan (ISP) dated November 9, 2009, indicated that "going to my day program and community outings" were what is most important to him. The ISP also included "it is important that I maintain optimal health, maintain a wheelchair that is in good repair and good relationships."</p> <p>d. On November 29, 2010, at 4:24 p.m., interview with the evening LPN revealed that in the 83 days since his admission, Resident #2 had received bed baths only, due to the facility's failure to obtain a shower gurney. At 7:15 p.m., review of a PCP note, dated September 29, 2010, and the corresponding 719A form verified that Resident #2 needed "a shower gurney."</p> <p>3. Resident #3 was admitted from a nursing home to the GHPID on August 5, 2010. Resident #3 did not receive new adaptive equipment as prescribed, and/or timely repairs to his existing adaptive equipment, as evidenced below:</p> <p>a. On November 29, 2010, at 3:45 p.m., Resident #3 was observed sleeping in a hospital bed in his bedroom. His wheelchair was observed across the bedroom; its left armrest was detached. Interview with the evening LPN revealed that the wheelchair had "recently" broken. The detached armrest had white adhesive tape wrapped around the bottom of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. They stated that he had been admitted from a nursing home to the facility</p>	(I 500)	<p>3. a-c Cross reference response to Federal Deficiency W127.3</p> <p>12/8/10</p>	12-8-10	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/16/2010
NAME OF PROVIDER OR SUPPLIER CARECO			STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(1 500)	<p>Continued From page 25</p> <p>on August 5, 2010, with that wheelchair, which was in operational condition at that time.</p> <p>On November 30, 2010, beginning at 11:15 a.m., review of Resident #3's ISP, dated September 7, 2010, confirmed that he utilized a wheelchair and that it was functioning at that time. Further review of the record, however, failed to show documentation of when the wheelchair had broken. At 3:00 p.m., review of Resident #3's PT records revealed that he had been assessed while in the nursing home and measurements were taken for a custom molded wheelchair. On August 9, 2010, the PT again noted the need for a custom molded wheelchair. Further review revealed that a 719A form was generated on September 28, 2010, six weeks later. Another four weeks passed then on October 20, 2010, the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the wheelchair vendor indicated there were problems with the resident's Medicare number. The QMRP stated that she had given the vendor the resident's Medicare card later on that same day. As of November 30, 2010, the resident was without a functioning wheelchair.</p> <p>b. On November 29, 2010, at 7:20 p.m., the QMRP and RD stated that Resident #3 had a decubitus ulcer on his sacral area when he was admitted to the GHPID. On November 30, 2010, at 3:00 p.m., review of Resident #3's PT records revealed that on August 17, 2010, the PT had recommended an air mattress to promote skin integrity. At 4:26 p.m., further interview with the QMRP revealed that the resident received the air mattress on November 13, 2010, almost three months after it was recommended by the PT.</p>	(1 500)			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/16/2010
NAME OF PROVIDER OR SUPPLIER CARECO			STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 500)	<p>Continued From page 26</p> <p>c. On November 30, 2010, at 3:10 p.m., further review of Resident #3's 718A form, dated September 26, 2010, revealed that the PCP also ordered a "rolling shower commode chair." A month later, on October 20, 2010, the wheelchair vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the wheelchair vendor indicated there were problems with the resident's Medicare number. The QMRP stated that she had given the vendor the resident's Medicare card later on that same day. As of November 30, 2010, two months later, the resident was without a "rolling shower commode chair."</p> <p>4. According to a Plan of Correction (PoC) dated September 23, 2010, the QMRP indicated that repairs would be made to Resident #4's wheelchair. As of November 30, 2010, the resident's wheelchair still had not been repaired and the condition of his wheelchair placed him at risk, as evidenced below:</p> <p>a. On November 30, 2010, at 9:20 a.m., Resident #4 was observed seated in his wheelchair on the lift mechanism of the facility's van. At the time, staff were loading residents to go to day program. Inspection of his wheelchair revealed that in addition to the previously identified repairs needed (mismatched wheels), the right anti-tipper was missing and the safety straps on both foot rests were unattached. After the problems with his wheelchair were brought to the staff's attention, they continued to put him on the van. At that moment, surveyors intervened and asked staff if they were aware of the administrator's directive regarding wheelchair safety and not leaving the facility. Staff then indicated that they were not aware of their</p>	(I 500)	<p>4. a,b Cross reference response to Federal Deficiency W127.4 12/8/10</p>	12.8.10	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2010
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NAME OF PROVIDER OR SUPPLIER

CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE

805 1/2 67TH STREET NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 500)	<p>Continued From page 27</p> <p>administrator's directive that had been issued the previous evening. Once they were informed of the directive ("resident will not be transported in... a wheelchair until it is properly repaired"), staff began wheeling Resident #4 toward the facility. The resident's right foot was observed dragging against the cement walkway for approximately four feet as they made their way back to the home.</p> <p>Record review on November 30, 2010, beginning at 9:50 a.m., revealed an OT evaluation, dated September 11, 2010, in which, the OT recommended that Resident #4 receive "a wheelchair consult as current wheelchair is too small for his height." On September 28, 2010, the PT evaluated the wheelchair and concurred, writing "Chair is too small. He is at risk for lower extremity injury." On the same day (September 28, 2010), the PCP ordered a new wheelchair and signed a 719A form. A month later, on October 20, 2010, the wheelchair vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the vendor informed the GHPID that they had secured approval for the new wheelchair. Measurements still needed to be taken before an order could be placed and the "entire process should take about 30 days."</p> <p>b. In an HRLA licensure deficiency report dated August 20, 2010, the GHPID was cited for Resident #4's wheelchair having "two different types of wheels ... rear left wheel was observed to have ridges in the tire while the right rear was observed to have a smooth tire." In their PoC, dated September 23, 2010, the facility stated that the "QMRP will contact the equipment vendor and have the chair repaired. The QMRP will maintain a log of contacts with the equipment</p>	(I 500)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/16/2010
NAME OF PROVIDER OR SUPPLIER CARECO			STREET ADDRESS, CITY, STATE, ZIP CODE 806 1/2 67TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 500)	<p>Continued From page 28</p> <p>vendor and follow-up to ensure that the repairs are effectuated as soon as possible," and "the QA will monitor for three months to ensure compliance." On November 30, 2010, beginning at 9:50 a.m., review of Resident #4's record failed to show evidence that the QMRP had maintained a log of contacts with the equipment vendor and there was no evidence of QA (quality assurance) monitoring in accordance with the accepted PoC.</p> <p>5. The GHPID failed to maintain Resident #5's wheelchair safety and obtain a shower gurney stretcher for bathing, as evidenced below:</p> <p>On November 30, 2010, at approximately 4:45 p.m., observation of Resident #5's wheelchair revealed that the safety strap on the left footrest was broken. At approximately 5:10 p.m., review of the resident's record revealed an "OT Equipment Assessment," dated November 1, 2010, in which the OT identified the broken strap on the foot rest and also recommended "a shower gurney stretcher for bathing." The QMRP was interviewed just minutes later, at which time she stated that she had not reviewed the OT's assessment prior to filing it in the resident's records. She indicated that she was unaware of the damaged safety strap. She also acknowledged that she was unaware that the OT had recommended a shower gurney for Resident #5, four weeks earlier.</p> <p>6. The GHPID failed to maintain Resident #6's wheelchair safety by providing the footrest on his wheelchair, as evidenced below:</p> <p>On November 30, 2010, at 7:35 a.m., Resident #6 was observed seated in his wheelchair in the living room. The wheelchair was without a right</p>	(I 500)	<p>5. Cross reference response to Federal Deficiency W127.5 11/1/10</p> <p>6. Cross reference response to Federal Deficiency W127.6 12/6/10</p>	<p>11-1-10</p> <p>12-6-10</p>	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0248	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED R 12/18/2010
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NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 806 1/2 57TH STREET NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{1 500}	Continued From page 29 footrest. At approximately 8:40 a.m., staff was asked about the missing footrest. The staff went to the resident's bedroom and returned moments later stating that they were unable to find his footrest. At 10:15 a.m., staff indicated that Resident #6 had stayed home from day program due to the condition of his wheelchair. Later that day, at 3:10 p.m., review of an OT evaluation, dated May 12, 2010, revealed that the OT had identified a broken strap and foot plate. When interviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the resident had been in need of a new footrest for months. They explained that his insurance company (an HMO) repeatedly had denied requests to have the wheelchair repaired. The GHPID failed to repair or replace the broken right footrest in the six month since the OT identified the need on May 12, 2010.	{1 500}		